Protecting academic freedom

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Competing interests: None declared.

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Excellence in academic medicine, as in all fields of research and innovation, depends on a work environment characterized by intellectual curiosity, relentless critical inquiry, and a passion to advance scientific knowledge and improve clinical practice. Such an environment also depends on academic freedom — the right of academic staff to teach, study and publish regardless of prevailing opinion, prescribed doctrine or institutional preferences, and the freedom to express critical opinion about workplace institutions and broad public issues.

Academic health sciences professionals in Canada, unlike their faculty colleagues in all other disciplines, typically do not have effective protection for their academic freedom. This lack of protection occasionally becomes visible, as in the widely publicized case of Nancy Olivieri,[1,2,3] the prominent hematologist and clinical researcher who was subjected to threats and harassment when she raised concerns about the safety profile of deferiprone. The University of Toronto failed to provide her with effective assistance, and the Hosptial for Sick Chidren subjected her to harassment that escalated into actions that almost ended her career.[1] A similarly widely publicized example is that of David Healy, a prominent psychiatrist who lost an offer of employment at the University of Toronto[4,5] after he suggested that the use of selective serotonin reuptake inhibitors may be associated with an increased risk of suicide.* Both Olivieri and Healy negotiated favourable settlements with the University of Toronto with the assistance of the Canadian Association of University Teachers (CAUT), a national organization representing academic staff at universities across Canada, and the University of Toronto Faculty Association.

The Olivieri and Healy stories, along with similar cases in Canada[6] and the United States[7,8] illustrate the fragility of academic freedom for clinical faculty, a term we use here to refer to health sciences professionals, generally with medical degrees, doctorates, or both, who hold simultaneous appointments at both a university and a teaching hospital or other university-affiliated health care institution.

Clinical faculty are more vulnerable to attacks on their academic freedom than nonclinical academic faculty for several reasons. First, clinical faculty have dual appointments: at universities, where academic freedom is given some recognition, and at health care institutions, which lack a strong tradition of recognizing the value of dissent and criticism. Second, unlike nonclinical faculty, who typically derive their income from the university payroll, clinical faculty secure the major part of their income from a practice plan or alternative funding arrangement that is independent of both the university and the health care institution. Thus, clinical faculty find themselves in a third institutional context,

* It is noteworthy that the US Food and Drug Administration subsequently issued a Public Health Advisory warning physicians, their patients and families of the possibility of suicidal thoughts and actions with 10 antidepressants, and that the British Medicines Healthcare Products Regulatory Agency earlier had taken a similar stance regarding the dangers of SSRIs, particularly in children.

in which their academic freedom can be put at risk. All other academics must deal only with the university. Finally, in Canadian universities most clinical faculty are legally excluded from membership in the bargaining units of faculty associations — which, in Canada, unlike the United States, include virtually all other academic staff. In their affiliated health care institutions, clinical faculty are virtually the only group with no collective agreement to protect their rights.[†]

The magnitude of the problem

Major initiatives are necessary to guarantee the academic freedom of clinical faculty, like their peers in all other fields of inquiry, to foster creative and innovative work. Over the past five years, CAUT has received dozens of complaints from clinical faculty about violations of their academic freedom in relation to their clinical and research work in universities and associated research institutes and hospitals. The details of most of these complaints remain confidential because of the potential jeopardy to the individual that exists precisely because institutional protection for academic freedom is lacking.[‡]

Testimonials from leaders in academic medicine indicate that physicians who present formal complaints to CAUT represent a small proportion of those who have suffered harassment, curtailment of academic advancement, or job loss as a result of their academic, or clinical viewpoints; their unwillingness to provide authorship on publications to undeserving colleagues; and their criticisms of institutional leadership and direction. The intense personal anguish of the situation, a desire to avoid becoming mired in the consequences of harassment, and a fear of adverse publicity if complaints become public, are all strong disincentives to lodging formal complaints.

Finding a solution

Troubled by the absence of protection for the academic freedom of clinical faculty, CAUT convened a group of five senior academic clinical faculty, each with many years of research and administrative experience, to develop recommendations to address the problem. The group's mandate was to develop a set of recommendations that, if implemented, would lead to greater protection of clinical faculty's academic freedom. The task force met six times over two years and developed recommendations covering the following four key areas.

1. Strengthen the rules governing academic freedom for clinical faculty. The rules, both formal and informal, that govern the working lives of clinical faculty are set out in a broad collection of written instruments — mission statements, guidelines, policies, affiliation agreements and employment contracts—that establish the norms of professional life at universities and health care institutions. Few such documents contain strong statements regarding academic freedom. An unequivocal commitment to academic freedom in these documents is important both to establish a legal and policy basis for faculty rights and to foster a culture of institutional respect for academic freedom. That said, we are well aware of the limitations of these sorts of statements. Ironically, the University of Toronto, site of both the Olivieri and Healy cases, has, in its 1992 statement on the purpose of the university, the strongest affirmation of academic freedom in Canada (www.utoronto.ca/govcncl/pap/policies/mission.html).

2. Ensure security of appointment and security of income for clinical faculty. To be effective, declarations of the right to academic freedom require additional protections. Security of employment, including security of income, is key to the exercise of academic freedom. Measures to protect the security of employment of clinical faculty should include eligibility for tenure with the university. Security in respect to relationships with health care institutions and funding mechanisms is more complex. To provide such security there must be established rules; the appointment or privileges to practise must be of renewable, limited terms and must be terminable only for just cause. The rules should specifi-

[†] The ability of MDs to be members of faculty or doctors-only unions is determined in Canada by provincial labour legislation. In most provinces, MDs are afforded either no or limited rights to be represented by a union (the Canadian Medical Association and provincial medical associations are not treated as unions nor, largely, do they function as such). Variation in provincial labour laws explains much of the variation in union representation for clinical faculty across universities. The absence of unionization for physicians in hospitals is a function of the legal context and of the tradition of medical administrators and medical staff being members of the same medical staff association.

[‡] "Jeopardy" can refer to many things. Examples that have been brought to our attention include dismissal, non-renewal of contracts, delayed or denied promotions, low salary increases, denial of access to research facilities, rearrangement of duties contrary to the clinical faculty member's wishes, denial of adequate support staff assistance, and being given inadequate office or laboratory space.

cally include protection for academic freedom such that the exercise of academic freedom cannot provoke nonrenewal, variance or termination.

3. Ensure access to natural justice for clinical faculty. To deal with conflicts involving the rights of individuals, fair and effective dispute resolution procedures are essential. These must be based on a set of legal principles deriving from "natural justice."[9] These principles include the right to be informed of allegations, the right to a hearing in a timely manner, the right to disclosure of evidence, the right to legal representation, the right to present evidence and to challenge the evidence presented by others, the right to know the reasons for any decision rendered and, most important of all, the right to an independent, unbiased external arbitrator. Universities, health care institutions and clinical funding plans must ensure that clinical faculty have access to dispute resolution procedures characterized by these principles. Virtually all other faculty members at Canadian universities have such access.

4. Strengthen the representational organizations of clinical faculty. The courts represent the pinnacle of natural justice within our society, but even there we are all aware that lack of resources may seriously compromise the likelihood of obtaining justice. Disputes between clinical faculty members and their universities or health care institutions pit individuals against organizations with substantial resources, expertise and power. For this reason, even effective mechanisms to adjudicate academic freedom disputes are, alone, insufficient to ensure that clinical faculty are treated fairly. Unless a clinical faculty member has meaningful representation, rights on paper are difficult, if not impossible, to enforce.

To ensure academic freedom, clinical faculty need to join or create effective organizations that represent them in their relationship with universities and university-affiliated health care institutions. These organizations should be characterized by a democratic structure, financial viability and independence, a legally enforceable collective bargaining relationship with the institution, the exclusion of persons in managerial positions, participation in the broader academic staff community, and intimate familiarity with academic freedom issues. Where membership in existing certified faculty associations or the creation of new certified faculty associations is not possible or feasible, clinical faculty should create robust uncertified associations. Such associations would be similar to faculty associations at non-unionized universities that negotiate collective employment contracts and enjoy access to automatic contributions to faculty representative organizations and independent grievance arbitration mechanisms.

Conclusion

Universities and affiliated health care institutions must make strong declarations of rights pertaining to academic freedom, provide security of appointment and income, allow access to dispute resolution systems characterized by natural justice, and permit clinical faculty to form powerful representational organizations. These steps are necessary to maintain the ability of clinical faculty and the institutions where they work to advance the boundaries of scientific knowledge and improve clinical practice.

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Citation: Protecting academic freedom. Guyatt GH, Cass CE, Jackson AC, Smith DH, Welch JP, Turk JL. *Open Med* 2008;2(2):e17-19.

Published: 22 April 2008